

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041170

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

317 500 2774
FILED OCT 18 19621. PLACE OF DEATH
a. COUNTY

St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN KochLength of stay in lb
MONSc. CITY
OR TOWN St. LouisInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Robert Koch Hosp.Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
2347a Warren St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First James

Middle Earl

Last Smith

4. DATE
OF DEATH

Month Sept.

Day 23

Year 1962

5. SEX

M

6. COLOR OR RACE

W

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

6/22/06

9. AGE (last birthday)

56

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HR
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Press Operator

10b. KIND OF BUSINESS OR INDUSTRY

Unemployed

11. BIRTHPLACE (City and state or country)

St. Louis

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

John Smith

13b. MOTHER'S MAIDEN NAME

Carrie Wasser

14. NAME OF HUSBAND OR WIFE

None

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Harold Smith 2347 a Warren St.

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Tuberculoses

INTERVAL BETWEEN
ONSET AND DEATH

16 years

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

Cor pulmonale

PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour Month, Day, Year
a.m. p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 6/18/1962 to 9/23/1962 and last saw her
Death occurred at 5:50 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Bernard Friedman, M.D.

22b. ADDRESS

Robert Koch Hospital

22c. DATE SIGNED

9-23-62

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE

9/26/62

23c. NAME OF CEMETERY OR CREMATORY

Bethany Cemetery

23d. LOCATION (City, town, or county)

St. Louis Co. Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Robert D. Kinealy 2228 St. Louis Ave.

25. DATE RECD. BY LOCAL REG.

9-25-62

26. REGISTRAR'S SIGNATURE

John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Herbert J. Lane Jr.

Licensed Embalmer No. 4800

P. O. Address Lickwood 22 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.